

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035599

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED SEP 18 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) Maysville		c. CITY OR TOWN Maysville	
Length of stay in 1b 4 Yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Sunset Nursing Home		d. STREET ADDRESS (If outside, give location) Maysville	
3. NAME OF DECEASED (Type or print) First S. Middle Grant Last Rice		4. DATE OF DEATH Month Sept. Day 5 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/16-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Illinois	
13a. FATHER'S NAME Latin Rice		13b. MOTHER'S MAIDEN NAME Sarah Bracken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. Graham Rice Weatherby Mo (R.F.D.)	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatosplenic pneumonia DUE TO (b) Bladder Calculus DUE TO (c) Benign prostatic hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2-3 days ? ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour 11:00 Month Sept. Day 5 Year 1963	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
STATE		21. I attended the deceased from Jan 9, 1963 to Sept 5, 1963 and last saw him alive on Sept 4, 1963	
22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS Maysville Mo.	
22c. DATE SIGNED 9/13/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 9/9-1963		23c. NAME OF CEMETERY OR CREMATORY Fairport	
23d. LOCATION (City, town, or county) Fairport Missouri		24. FUNERAL DIRECTOR Pilcher Funeral Home Maysville Mo.	
25. DATE RECD. BY LOCAL REG. 9-14-1963		26. REGISTRAR'S SIGNATURE [Signature]	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
O. R. Pilcher

Licensed Embalmer No. 3960

P. O. Address Maysville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

PROPRIETARY

PROPRIETARY

PROPRIETARY

PROPRIETARY